

060540

2387

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8720124
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
				Mary	Beatrice	Berger	July 15, 1987				1:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
== female		white		April 21 1917			70 Yrs.		YRS			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA					Kent					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown		Kent & Queen Anne's Hospital, Inc.				Seamstress						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland	Kent	Rock Hall			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Bayside Ave. 21661					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
George		T.		Berger	Mary A. Moore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
no		217 36 1407		Frances B. Jones		Bayside Ave Rock Hall, Md. 21661						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE ACUTE MYOCARDIAL INFARCTION</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>END STAGE ANKYLOSING SPONDYLITIS</u> <u>MASSIVE MULTINODULAR GOITER</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>7/15</u> 19 <u>86</u> to <u>7/15</u> 19 <u>87</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>7/15</u> 19 <u>87</u> , and that in <input type="checkbox"/> (my) our opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
Virginia U. Collier						<u>7/16/87</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		PO BOX 599, CHESTERTOWN, MD								
VIRGINIA U. COLLIER												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		7/17/87		Wesley Chapel Cemetery		Rock Hall, Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS		J. Willis Wells		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
J. Willis Wells		Chestertown, Md.				JUL 22 1987		<u>John W. Williams</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, then please remove carbon papers. Page 1 and 2 should be detached for use at the funeral parlor. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If Item 21 is marked or Item 22 is any injury, or other traumatic event, the medical examiner must be notified.)

referred by the hospital or attending physician

10 ES JUL 04 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and attach to the death certificate. Item 21 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be called for an examination.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 / 20 / 25 REG. NO. 20725											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
THERESA L. BULLOCK						JULY 18, 1987			8:55 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
FEMALE		WHITE		JAN. 17, 1912			75			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
MARYLAND		U.S.A.					KENT COUNTY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CHESTER TOWN		RT. 4 Box 302 C1					SALES			DEPT. STORE	
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MARYLAND		KENT					RT. 4 Box 302 C1			21620	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		215 10 7641		Family Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute G-1 Hemorrhage APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF (b) Tardive dyskinesia between onset and death Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 7-27, 1987, to 7-18, 1987, that (I) (was) lost now the deceased alive on 7-2 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
Ralph E. Libby, MD										7-19-87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 7-22-1987		23c. NAME OF CEMETERY OR CREMATORIAL PARKWOOD CEM.		23d. LOCATION CITY OR TOWN PARKVILLE BALTO. MD.		25a. DATE RECEIVED BY REGISTRAR JUL 25 1987			
BURIAL		8800 HARFORD ROAD ADDRESS		EVANS CHAPEL OF MEMORIES						25b. REGISTRAR'S SIGNATURE Julie Sanders-Kendall	
24. FUNERAL DIRECTOR NAME											
Evans Chapel of Memories											

18 JUL 1980

1005 JUL 1988 20

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06/22/15 AUG 11 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20121

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
William WESLEY HANDY						7/31	19	87	62		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	Black	11 9 1930	56 yrs.	MONTHS	DAYS	7/31	19	87	72		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia	USA			Kent							
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Worton		RFD					Laborer			21678	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Maryland	Kent	Worton	Rte 298		RFD						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
George Handy			Gladys White								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 4/10/51 to 10/31/53		17. INFORMANT Medical Records		ADDRESS Hospital Perry Point Vet. Adm.					
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		arterio sclerosis CVD									
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last.		DUE TO, OR AS A CONSEQUENCE OF									
(b)		DUE TO, OR AS A CONSEQUENCE OF									
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Diabetes mellitus - Mental retardation											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Robert W. Farr		M.D.		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)		Kent County		ADDRESS							
EXAMINER'S NAME (TYPE OR PRINT)		Robert W. Farr		Kent County		Chestertown, Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/8/87		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		8/8/87		Macedonia Cemetery		Bloxom, Virginia					
24. FUNERAL DIRECTOR NAME		ADDRESS		J. Willis Wells		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. Willis Wells		Chestertown, Md.		AUG 07 1987		Davidson. Readall					

085512 081181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked as "Yes" shown any injury, or other traumatic event, the medical examiner should be informed.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20 / 28
REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	P		
WILLIAM A. KNELL (Jr)						July 12, 1987				6:55	M		
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 17, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co		MD.					
10. CITY OR TOWN OF DEATH Rock Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Contractor		12b. KIND OF BUSINESS OR INDUSTRY Retired							
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Mercer Ave 21661					
14. FATHER'S NAME FIRST Wil liam A. Knell (Sr)		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Mary A. Kepp HEPP		MIDDLE		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 205 05 2026		17. INFORMANT Annabell Price		ADDRESS Rock Hall, Md. 21661		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Michael Bienefeld</u>		DEGREE M.D.		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/13/1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Bienefeld M.D.		22e. ADDRESS Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 888888, Burial		23b. DATE 7/15/87		23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.		23d. LOCATION CITY OR TOWN Rock Hall, Md.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME J. Willis Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUL 22 1987		25b. REGISTRAR'S SIGNATURE <u>J. Willis Wells</u>							

168.11.88.0000

060536

JUL 23 1977 STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2	REG NO.	129				
ATE	KNOWN	XX	MONTH	DAY	YEAR	24 HOUR
OF	ESTI-					
ATH	MATED	<input type="checkbox"/>	7/17/87	19		P
DATE	MONTH	DAY	YEAR	24 HOUR		
OUNCED	July	17	87	120		
DEAD					M	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

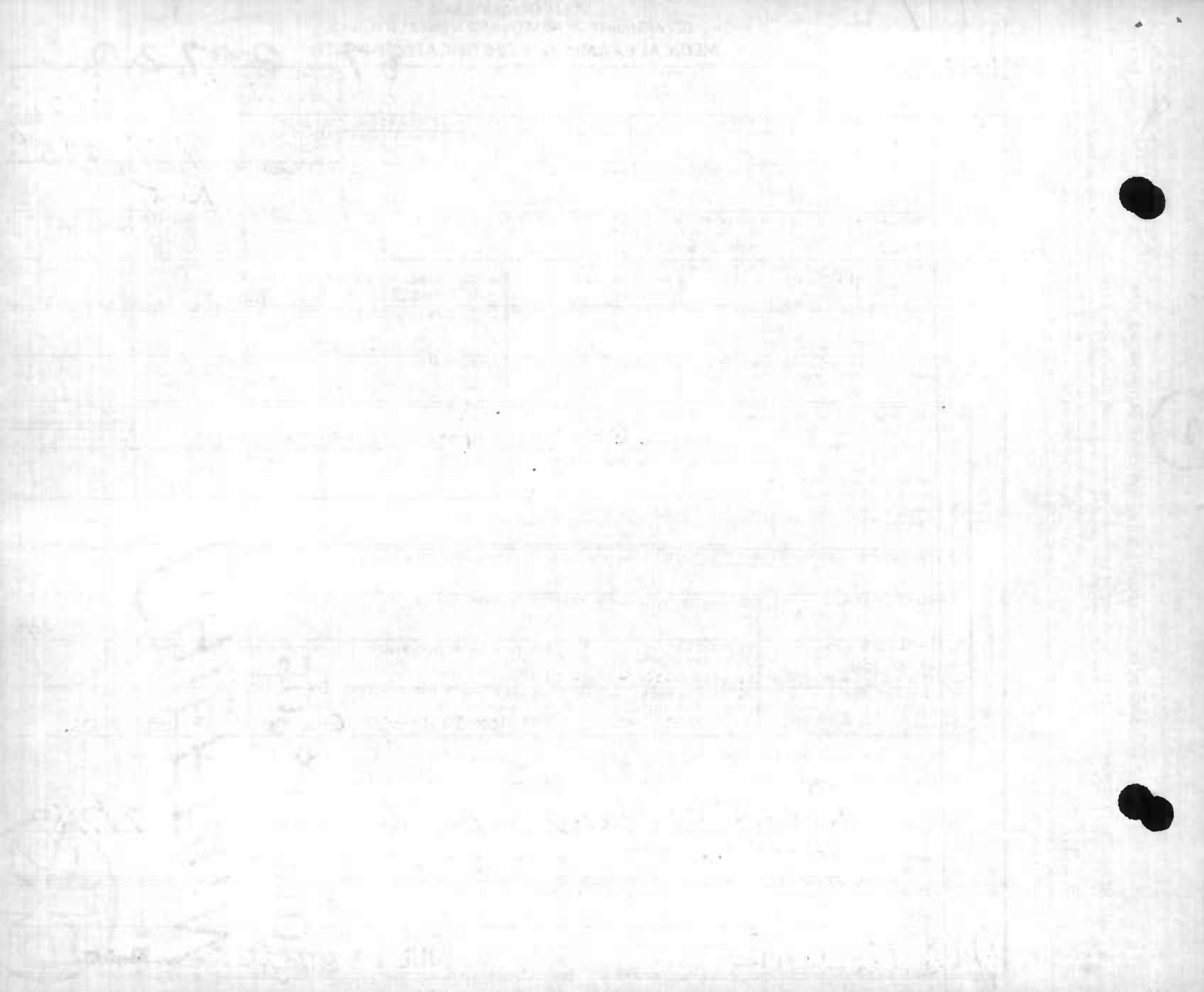
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR		
MARY LEE LECUK						7/17/87, 19				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	
female	white	July 6, 1928	59	MONTHS YRS.	DAYS	HOURS	78	19	720	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		USA			NEVER MARRIED DIVORCED <input type="checkbox"/>		Kent			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Kennedyville		At Home Rte # 213 Box # 301			Nurse's Aide		21645			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rte # 213 Box # 301		MD		
Maryland		Kent	Kennedyville							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
William Gibson		Maude Huffman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
no		217 24 9544			Maxine Tweed		Rte # 213 Box 301 Kennedyville, Md. 301			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ASCVD										
DUE TO, OR AS A CONSEQUENCE OF Probable congestive heart failure										
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (b)										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Robert W. Farr</i>										TITLE (SPECIFY) M.D. <i>Robert W. Farr</i> MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT)										DATE 7/17/87 SIGNED
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 7/20/1987		23c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery		23d. LOCATION CITY OR TOWN Elkton		COUNTY STATE Cecil Co. Maryland		
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUL 22 1987		25b. REGISTRAR'S SIGNATURE <i>J. Willis Wells</i>				

TO ES JUL 86 2030

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A DIVISION OF VITAL RECORDS BURIAL/PRESCRIPTION FORM. PAGE 2 SHOULD BE USED AS A DIVISION OF VITAL RECORDS Cremation, or Memorial. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BUREAU OF VITAL RECORDS, 21201, BALTIMORE, MARYLAND.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR			2. DATE KNOWN OR ESTIMATED DEATH										REG. NO. 20730					
11. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST				MONTH DAY YEAR		2b. HOUR						
EDWARD EVERETT MARTIN										7 7 1975 10		M						
12. SEX Male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR	
March 22 1910 77 yrs														7 7 1975 10			M	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED		NEVER MARRIED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Kent						
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Mechanic			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box # 34 Rock Hall, Md. 21661		Spring Cove								
14. FATHER'S NAME FIRST MIDDLE LAST Walter B. Martin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Taylor															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 221 07 3611			17. INFORMANT Margaret A. Martin			ADDRESS Box 34 Spring Cove Rock Hall Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 911 IMMEDIATE CAUSE (a) Choked on a piece of aspirated meat DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH short s																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:06 P.M. July 7 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) see above in part 18												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET PO Box 34 Spring Cove Rd Rock Hall Md. CITY OR TOWN COUNTY STATE												
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. Deputy MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr ADDRESS Chestertown, Kent County Md.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/10/87			23c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery			23d. LOCATION CITY OR TOWN Wilmington, Del.			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME J. Willis Wells			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JUL 13 1987			25b. REGISTRAR'S SIGNATURE J. Willis Wells									
BP		DHMH-17 (VR A15 ME (5)) 15M7/77																



236
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 2a. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. FORMS 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item Part 2, G-631, 9/24/87, by Med. Exam. STATE OF MARYLAND
 FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1- STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC NO. 20731

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b HOUR
Catherine G. O'Neil						<input checked="" type="checkbox"/>	7	6	1987	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR. MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN	2c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR
Female	White	July 31, 1945	41 yrs.			<input checked="" type="checkbox"/>	7	6	1987	5:32 P.M.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Conn.		US					Kent County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Chestertown		Kent and Queen Anne's Hospital				Not Employed				
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Hurllock		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> P.O. Box 393 21643			
14. FATHER'S NAME John		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Wanda		Catherine Sikorsky				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		17. INFORMANT Wanda C. O'Neil		Item # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9102		Drowning				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		DUE TO, OR AS A CONSEQUENCE OF								
(b)		DUE TO, OR AS A CONSEQUENCE OF								
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
Mental retardation and skeletal deformities										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOURS MONTH DAY YEAR 4:45 P.M. 7 6 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Subject drowned while swimming				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) swimming pool		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		Camp Fairlee Manor, Chestertown, Kent, MD.				
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>				and in my opinion				
ACTUAL SIGNATURE		M.D. Deputy Chief				MEDICAL EXAMINER			DATE SIGNED 7-7-87	
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.				ADDRESS 111 Penn Street, Balto. Md. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE Burial 7/10/87		23c. NAME OF CEMETERY OR CREMATORIAL Lady of Good Counsel		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. SECRETARY DOR. MD.		
24 FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR JUL 10 1987		25b. REGISTRAR'S SIGNATURE Julia Dixon-Lindau		
THOMAS FUNERAL HOME CAMBRIDGE, MD.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Item 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 20132		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Ida Elizabeth Rochester						7- 9 87			12:27 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female		Blk		MONTH	DAY	YEAR	57	IF UNDER 24 HRS				
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH			8. IF UNDER 1 YEAR		
Md		USA					Kent County			MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		Kent and Queen Anne's Hospital, Inc.		Domestic								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13e. STREET ADDRESS / ZIP CODE					
Md		PA		Centreville			R#2 Bay 299					
14. FATHER'S NAME		MIDDLE LAST		15. MOTHER'S MAIDEN NAME								
William H		Copper		Mary E								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
2		171246098		Cretchen			Seney Rochester					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										(b) Ca of lung, with lymphogtic spread and liver fail.		
DUE TO, OR AS A CONSEQUENCE OF (b)										(c) Respiratory failure		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a COPD.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF FIFTH, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 6/27, 1987, to 7/9, 1987, that (I) (we) last saw the deceased alive on 7/9, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.												
22b. SIGNATURE Kin Kue Wun										22c. DEGREE MD		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kin Kue Wun										22e. ADDRESS 216 High St, Chestertown, Md. 21620		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. STATE			
Burial		7/14/86		Rochester			Cem. In Chesapeake		MD			
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Henry H DeGull		Estate and		JUL 23 1987			Julia D. Dillard-Lindell					

18 JUL 2000

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20133
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A FUNERAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, AT 201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert	MIDDLE Arthur	LAST Rose	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> <input type="checkbox"/> MONTH 7/25/87	DAY YEAR 1987	2b. HOUR M 12:10
SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Jan 18, 1966	6 AGE (IN YEARS LAST BIRTHDAY) 21 yrs.	7 IF UNDER 1 YR. MONTHS DAYS 8 IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 7/25/87	MONTH DAY YEAR 1987	2d. HOUR P 12:10
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County, MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seaman U. S. Navy (Active)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS High St. 21620		
14. FATHER'S NAME FIRST Gerald Rose		15. MOTHER'S MAIDEN NAME FIRST Mary Louise Sampson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes U. S. Navy (Presently)		16b. SOCIAL SECURITY NO. 220 04 0921		17. INFORMANT 631 High Street Gerald Rose		ADDRESS 21620 Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8/22 IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:00 <input checked="" type="checkbox"/> 7/25/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) motorcyclist/auto collision			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET Hardy Point Rd., Chestertown, Kent Co., Md.		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Margraita Korell</u> M.D. TITLE (SPECIFY) <u>Margraita Korell</u> M.D. Assistant MEDICAL EXAMINER DATE SIGNED 7/26/87							
EXAMINER'S NAME (TYPE OR PRINT)		111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 29 1987		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN 3401 Bladensburg Road	
24. FUNERAL DIRECTOR J. Willis Wells Chestertown, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 29 1987		25b. REGISTRAR'S SIGNATURE J. Willis Wells	
BP		DHMH - 17 (VR A15 ME (5))					

061657 100-201

06/22/21 AUG 11/87

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED "WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, FILE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

7

FOR
1- STATE
REGISTRATION
DECEASED NAME
(TYPE OR PRINT) = ROBERT GRIFFITH SOLLINGER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 REC NO. / 3 4

3 SEX Male 4 RACE white 5 DATE OF BIRTH MONTH DAY YEAR 4/14/1924 6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS. 7 IF UNDER 1 YR. MONTHS DAYS HOURS MIN 8 IF UNDER 24 HRS. MONTHS DAYS HOURS MIN

2a DATE KNOWN OF ESTI- DEATH MATED 7/31/87 19 1:16A M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chester Pa. 7b CITIZEN OF WHAT COUNTRY? USA 8. MARRIED NEVER MARRIED WIDOWED DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.

10 CITY OR TOWN OF DEATH Chestertown 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber & Electrician

12b KIND OF BUSINESS OR INDUSTRY

13a STATE Maryland 13b COUNTY Kent 13c CITY OR TOWN Worton 13d INSIDE CITY LIMITS? YES NO RFD 13e STREET ADDRESS Wymont Park 21628

14. FATHER'S NAME FIRST Robert G. Sollinger (Sr.) LAST

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wilson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no 16b. SOCIAL SECURITY NO. 191 14 6388 17. INFORMANT ADDRESS Roger Cattermole Funeral Service

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)

19. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO

21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Robert W. Farr M.D. Deputy MEDICAL EXAMINER

EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr Chestertown Kent Co. Maryland ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 8/4/87 23c. NAME OF CEMETERY OR CREMATORY Parker Ford Baptist Church 23d. LOCATION CITY OR TOWN Parker Ford Pa. Chester Co.

24. FUNERAL DIRECTOR J. Willis Wells ADDRESS Chestertown, Md. 25a. DATE REC'D. BY REGISTRAR 7/30/87 25b. REGISTRAR'S SIGNATURE

07/84 25M BP DHMH - 17 (VR A15 ME (5))

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62214 AUG 11 1987
STATE
REGISTRAR
DECEASED NAME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

REG. NO. 20135

1. DECEASED NAME (TYPE OR PRINT) EMORY DORSEY SOMERVILLE			2a. DATE OF DEATH MONTH DAY YEAR July 31, 1987	2b. HOUR 7	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1907	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Farm & other
13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Worton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rte # 1 Box 346 21678	
14. FATHER'S NAME FIRST MIDDLE LAST William Somerville	15. MOTHER'S MAIDEN NAME Ella Dorsey			MIDDLE	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 212 12 3221	17. INFORMANT Corinthia Somerville	ADDRESS Rte # 1 Bx 346 Worton 21678		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>175/40</u>					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Severe COPD					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> 19 <u>75</u> , to <u>7/31</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) certify the body after death.					
22b. SIGNATURE <u>Wayne D. Benjamin</u>			DEGREE	22c. DATE SIGNED 7/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin			22e. ADDRESS Chestertown, Md. 21620		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 5 1987	23c. NAME OF CEMETERY OR CREMATORIUM St. George Cemetery	23d. LOCATION CITY OR TOWN Worton, Md. 21678	23e. POINT Point	STATE
24. FUNERAL DIRECTOR NAME James A. Perkins	ADDRESS Rock Hall, Md.	25a. DATE REC'D BY REGISTRAR AUG 07 1987		25b. REGISTRAR'S SIGNATURE <u>James A. Perkins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN) The foregoing requires that the death sentence be executed within 24 hours after death. Page 4 may be

NO HOSPITAL OR ATTENDING PHYSICIAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon paper, sign and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 / 20 / 36
1 - STATE REGISTRAR DECEASED NAME (LAST, FIRST, MIDDLE) VICTORIA ELLENBERG WAGNER		2a DATE OF DEATH MONTH DAY YEAR July 22, 1987		2b HOUR 9:45 P M
3. SEX Female		4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR August 22, 1912	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent
10. CITY OR TOWN OF DEATH Georgetown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Gregg Neck P.O. Box 161		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asso. Editor
13a. STATE Maryland		13b. COUNTY Kent	13c. CITY OR TOWN Georgetown	12b. KIND OF BUSINESS OR INDUSTRY Printing
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Ellenberg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hanna Mae McCulloch		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 056 01 8684	17. INFORMANT Myron B. Morris	ADDRESS P.O. Box # 161 Georgetown, Md. 21930
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMA OF LUNG</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>CARCINOMA OF COLON</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to 7/22/87, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>L. A. Wagner, M.D.</i>		DEGREE	22c. DATE SIGNED 7/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L. A. Wagner, M.D.</i>		22e. ADDRESS 206 Bon St Elkton MD 21921		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/23/87	23c. NAME OF CEMETERY OR CREMATORIAL MacNabb's Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Md.
24. FUNERAL DIRECTOR NAME <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.	25a. DATE REC'D. BY REGISTRAR Jul 23 1987	25b. REGISTRAR'S SIGNATURE <i>John Willis Wells</i>

1045 JUL 8 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please DETACH this paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 20131
1. FOR STATE REGISTRAR	2. DECEASED NAME (TYPE OR PRINT) GEORGE L WILSON			3. DATE OF DEATH MONTH DAY YEAR July 19, 1987	4. HOUR P M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 25, 1927	6. AGE (IN YEARS LAST BIRTHDAY) 60 Yrs YRS	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Worton RFD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) At Home Rte # 1 Box #374			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm Laborer	12b. KIND OF BUSINESS OR INDUSTRY MD.
13. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Worton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rte # 1 Box 374	21678
14. FATHER'S NAME FIRST: Isaac MIDDLE: Wilson LAST:	15. MOTHER'S MAIDEN NAME FIRST: Emma MIDDLE: Butler LAST:				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 20 7422	17. INFORMANT Beatrice Wilson	18. ADDRESS Rte # 1 Box # 374 Worton, Md. 21678		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>end stage arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael Bienefeld</u>	22c. DEGREE MD	22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED JUL 23 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Bienefeld	22e. ADDRESS Chestertown, Md. 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/23/87	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive Church Cem.	23d. LOCATION CITY OR TOWN Worton, Md. RFD	23e. COUNTY Worton	23f. STATE Md.
24. FUNERAL DIRECTOR NAME <u>James A. Perkins</u>	25a. DATE REC'D. BY REGISTRAR JUL 23 1987			25b. REGISTRAR'S SIGNATURE <u>Julie Darden-Pendleton</u>	
DHMH - 16 50M 4/83 (VRA 15, 4)					

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1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20138

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Reba Spencer Wilson							July 4, 1987				11:00pm
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Female		Cauc		MONTH 10/22/1904 DAY YEAR			82			MONTHS DAYS	
7b. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS	
MD		USA					Kent			HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Betterton		111A Erickson Ave. 21610		Nurse			Medical				
13a. STATE Florida		13b. COUNTY		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 122 Filmore Ave. 99999				
14. FATHER'S NAME FIRST Robert		MIDDLE H		15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE E.			LAST Anderson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
N/A		N/A 203-14-0256		Elizabeth Webb, Betterton, MD 21610			months				
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Arteriosclerotic C-Vascular Disease (c) Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> , 1987, to <u>7/4</u> , 1987, that (I) (we) last saw the deceased alive on <u>6/13</u> , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. Green</u>		22c. DEGREE <u>MD</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>7/18/87</u>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CG BACON</u>		22g. ADDRESS <u>Chest Grown, Ad 21610</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/9/87		23c. NAME OF CEMETERY OR CREMATORIAL Still Pond			23d. LOCATION CITY OR TOWN Still Pond			COUNTY Kent	
24. FUNERAL DIRECTOR NAME Gary Fellows/Box 270/Millington, MD 21651		ADDRESS JUL 13 1987		25a. DATE REC'D. BY REGISTRAR JUL 13 1987			25b. REGISTRAR'S SIGNATURE <u>g. fellows</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified.

